

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ARIXTRA (fondaparinux sodium)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt. _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

TELEPHONE AUTHORIZATION OR WRITTEN REQUEST

CRITERIA:

- ▶ Pre-operative for 3 days to stop coumadin prior to surgery
- ▶ Post-operative for 5 days to achieve therapeutic INR on Coumadin
- ▶ Post-operative prevention of DVT in patients with abdominal surgeries and below i.e. hip, knee, and ankle not including foot and toes. Maximum of 10 days
- ▶ Treatment of acute DVT when administered in conjunction with coumadin

OR

- ▶ Treatment of PE when administered in conjunction with coumadin when initial therapy is administered in the hospital.

RE-AUTHORIZATION:

Based on INR. Considered on an individual basis.